Community Transformation Grant RFA Conference Call
Friday, December 16, 2011

Grantee Requirements

Each funded multi-county collaborative will be expected to do the following:

- Identify one health department in the collaborative as the lead agency. This agent must have experience in implementing policy, systems and environmental changes and in managing grant projects involving multiple areas and organizations. It is critical that the lead agent has the support of its Board of Health and County Commissioners to distribute funds to other counties within the region and/or fund staff to work primarily in other counties within the region. The lead agency will be required to do the following:
    - Develop a Memorandum of Understanding with each of the counties it works with on this project (through the multi-county collaborative approach).
    - Employ two full-time CTG Community Coordinators to serve the entire collaborative area. One of the Coordinators must be based in the lead agency. If the lead agency is not in a rural county, then the other Coordinator must serve rural counties. These Coordinators will be responsible for:
        - Facilitating community change, including partnership development, coalition building/community organizing and partner communications.
        - Providing monthly fiscal reports to the state
        - Providing monthly programmatic reports to the state
        - Updating the lead agency's health director on programmatic and fiscal issues regularly
        - Linking activities with those of the Hypertension/ High Cholesterol Quality Coach (HHQC) based in practice-based settings determined by DPH to address activities in Strategic Direction III.
    - Designate a fiscal staff member to:
        - Monitor expenditures monthly, including salaries, fringe, contracts and operating line items
        - Monitor additional funds leveraged through CTG
        - Monitor subcontracts awarded through CTG grant
        - Project unspent funds by 3rd quarter of each year

- Designate a collaborative lead for communications to support statewide CTG communications strategies and serve as the liaison to the state CTG Communications Specialist. This person is not required to be based in the lead agency.

- Designate collaborative leads for each of the four chosen strategies. These positions will submit monthly reports on progress toward action plan objectives to the CTG Community Coordinator and are not required to be housed in the lead agency.

- Establish a CTG Leadership Team to direct the projects for each of the Strategic Directions. Key partners should represent the diversity of the area served and include representatives from AHEC, Community Care of North Carolina networks (CCNC), local health departments, colleges/community colleges, affordable housing, city or regional planning departments, schools, Cooperative Extension, primary care providers, hospital, business, youth groups, Area Agencies on Aging, faith-based organizations, and other community-based organizations.

- Develop an annual action plan to change policies and systems with jurisdiction-wide impact to support healthier lifestyles in collaboration with DPH. Action plans and budgets will be submitted annually.

- Implement interventions specifically targeting populations at greater risk for chronic disease (e.g. African Americans, people with disabilities, rural populations and low-income populations).

- Include representatives of the target population groups mentioned above and or target organizations/systems in the planning and implementation of the strategies.

- Monitor progress on all activities and report on a monthly basis. Collaboratives must commit to specifically evaluating the impact of select strategies on decreasing health disparities. Strategies for more intensive evaluations will be identified collaboratively by state and community project partners. Funded collaboratives are expected to dedicate sufficient resources (up to 10% if needed) to evaluation.

- Engage Chronic Disease and Injury staff in intervention planning and implementation, including utilizing technical assistance from content experts in DPH.

- Program staff will be required to participate in DPH training events. It is strongly recommended that health directors also participate. The following is a tentative training schedule for Year 1:

Kickoff Event for state and community partners	April 2012
Webinars for Each Strategy with Health Equity Approach	April, May, June and July 2012
NC Action Institute for community partners	September 2012

North Carolina's CTG Priorities

North Carolina's overall efforts will be evaluated based on the strategies listed below. Applicants are expected to implement one strategy in each of the Strategic Directions. Collaborators must address Strategy 1 in Strategic Direction I and one strategy each in Strategic Directions II A and II B. Additionally they must describe how they will work with state partners and CCNC networks in their areas to support the implementation of Strategy 9 in Strategic Direction III.

Strategic Direction I: Tobacco free living
1. Increase smoke-free regulations of local government buildings and of indoor public places.
2. Increase tobacco-free regulations for government grounds, including parks and recreational areas.
3. Increase smoke-free housing policies in affordable multi-unit housing and other private sector market-based housing.
4. Increase the number of 100% tobacco-free policies on community colleges campuses and state and private university/college campuses.
Strategic Direction II A: Active Living
5. Increase the number of communities that implement comprehensive plans for land use and transportation.
6. Increase the number of community organizations that promote joint use/community use of facilities.
Strategic Direction II B: Healthy Eating
7. Increase the number of convenience stores that increase the availability of fresh produce and decrease the availability of sugar-sweetened beverages.
8. Increase the number of communities that support farmers' markets, mobile markets, and farm stands.
Strategic Direction III: High impact evidence-based clinical and other preventive services
9. Increase the number of health care providers' quality improvement systems for clinical practice management of high blood pressure and high cholesterol, weight management and tobacco cessation.
10. Increase the number of healthcare organizations that support tobacco use screening as a vital sign and referral to QuitlineNC and/or local tobacco cessation services.
11. Increase the number of community supports for individuals identified with high blood pressure/cholesterol and tobacco use (e.g. Chronic Disease Self-Management Program, Eat Smart, Move More, Weigh Less programs, tobacco cessation programs).

Questions submitted as of 5 pm on December 14, 2012

1. If LHDs from counties outside our region decide to partner with us (since they are part of our incubator partnership and regularly collaborate with the counties in our region), will additional funding be to the region (since we will be impacting more counties)?
   Answer: Funding will be distributed to 10 regions in the amount of $400,000. Additional funding will not be given based on the number of counties that may be added to a particular region.

2. What is the plan for run-out costs? For example if staff are hired for the grant, but need to be "RIF"ed when funding runs out, how would unemployment costs be handled?
   Answer: Any costs incurred outside the agreement timeline for CTG must be handled by the LHD and employee. Unemployment expenses are not an allowable cost.

3. Can we use NC Public Health Alliance for hiring staff under the CTG? Would the administrative costs for the hiring agency be allowable (fringe)?
   Answer: Fringe costs for the employee are allowed. Administrative costs for the hiring agency are not allowed.

4. Can rent be charged in our budget for housing staff for the CTG?
   Answer: Office rent is allowed for staff assigned to CTG.

5. Can the Lead Agency and the Fiscal Agent be different LHDs?
   Answer: No. The lead agency is defined as the fiscal agent for CTG.

6. Will money come to us through the WORM? Will any funds be provided up front?
   Answer: Funds will come through the WIRM. No up-front funds will be provided, and reimbursements will be made on a monthly basis.

7. Can we budget for supervision?
   Answer: Supervision may be included in the budget, but please justify how this expense supports the project.

8. Define supplanting. (Also, if a current staff member's duties and attached funding change, adding CTG duties should allow CTG funding to be used, as well; is that correct?)
   Answer: Funds may not be used to pay for existing positions currently working on other projects that are supported by other funding. All positions supported by CTG funding must be working on efforts specifically addressing CTG.

9. On page 8: NC's CTG Priorities, the terms "applicants" and "collaborators" are used; are these same?
   Answer: They are the same.

10. On page 8: NC's CTG Priorities, the applicant/collaborator is instructed to implement one strategy in each of the strategic directions. It is clear that you would like us to implement strategy 1, as well as 5 or 6, and 7 or 8. We have also been told to describe how we will work with others to support strategy 9. Would you also like us to implement 9, 10 or 11? If so, then at this point are 2, 3, and 4 to be implemented at a later date? Please clarify.
    Answer: Applicants must describe how they will address at least one strategy in each of the four Strategic Directions. Applicants are not expected to address every strategy in year 1. For example, as some strategies are accomplished (such as smoke-free government buildings), the grantee can move on to another area in Tobacco Free Living. The grantees' work with others to support strategy 9 is sufficient for addressing *Strategic Direction III, High impact evidence-based clinical and other clinical preventive services.*

11. We need to know more about what the State's plans are in order to better describe how we will work with the State.
    Answer: This project is a partnership between DPH, local health departments and their community partners. DPH Program staff will be actively involved in the local CTG Leadership Teams and their activities. Grantees are encouraged to document their needs for training and technical assistance.

12. Please provide a definition of a Community Based Organization:
    Answer: A community based organization, public or private nonprofit (including a church or religious entity) that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs. (http://nnlm.gov/sea/funding/cbodef.html ; Accessed 10-12-11)
    A general definition of a faith-based organization is "an organization, group, program or project that provides human services, and has a faith element integrated into their organization". (Rural Assistance Center: http://www.raconline.org/info_guides/faith/faithfaq.php#faith ; accessed 10-12-11)

13. The RFA is confusing in terms of how many strategies you want us to address in our plan. Page 4 tells us to pick one strategy in each of the four Strategic Directions but on page 9 it looks like you really want us to work on all 8 strategies in I, IIA, and IIB and to collaborate on III with Quality Coaches---which is the direction the Division wants us to pursue?
    Answer: Applicants must choose one strategy in each of the four Strategic Directions. The activities listed under each Strategic Direction starting on page 9 of the RFA are meant to be examples only. Please also refer to the response in Question 10.

14. Did the CDC request that rural counties be identified or determined by the MSA?
    Answer: CDC has stated that, for the purposes of CTG, all counties that are not part of a Metropolitan Statistical Area are considered "rural." Metropolitan Statistical Areas (MSAs) are geographic entities defined by the Office of Management and Budget (OMB). The process of identifying an MSA begins with the identification of a core urban area of 50,000 or more population (which may be contained in a single county or spread across multiple counties). Then, the MSA is defined as the county or counties containing the identified core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core.

    For more information: http://www.census.gov/population/metro/

15. If a region applies, can the region identify a health department district to be the fiscal agent and another health department to be the lead communication point, or does the fiscal agent/communication point have to be the same?
    Answer: The lead health department is the fiscal agent. This health department will house one of the CTG Community Coordinators. Other positions can be housed where needed.

16. Will the primary interaction for this grant be with the CDC or State?
    Answer: NC communities will interact directly with DPH.

17. Will lead counties be restricted from applying for additional funding from the Healthy Communities Program at DPH (Eat Smart Move More, etc) for the 5 year CTG span? Will there be other confirmed or planned funding opportunities available during this period?
    Answer: The lead health departments are not restricted from applying for the new Healthy Communities grants that will be released in early 2012 or the current ESMM grant program. We do encourage regions to work together to coordinate funding opportunities based on need in the region.

18. Funding from the Tobacco Prevention and Control Branch currently includes CDC funding for regional tobacco prevention coordinators. Is there any indication that this CTG funding may be replacing that funding stream in the future?
    Answer: CTG funding is not intended to replace any other funding. The Tobacco Prevention and Control Branch encourages its grantees to actively and strategically expand their work in the regions through this opportunity.

19. The RFA mentions engaging CDI staff from DPH in planning and technical assistance. Can you provide a clearer picture of what that TA will look like? Will there be a resource network identified (content experts, etc) ahead of time so that applicants can incorporate this into their respective applications?
    Answer: There will be positions dedicated to CTG and these positions will coordinate with staff in the Physical Activity and Nutrition, Tobacco Prevention and Control, Heart Disease and Stroke Prevention and the Office of Minority Health and Health Disparities in providing technical assistance. Each region will have a Program Consultant. These positions have not yet been filled.

20. Program and fiscal monitoring/reporting will be an important role. What type of reporting will be expected –web based system or other reports? How often?
    Answer: Fiscal reporting will be conducted monthly using an excel spreadsheet format. Program reporting will be conducted quarterly using a web-based system.

21. If all counties (in a region) are addressing Active Living, do all have to focus on land use/transportation plans OR joint use, or can there be a combination of these within the region as long as each Strategic Direction is addressed? (beyond the required strategies outlined for Strategic Direction I (#1) and III (#9)
    Answer: The specific strategies addressed by each region will not be prescribed. DPH will provide tools and technical assistance to help regions determine which activities would have the most impact in areas of highest need.

22. Is there a deadline for hiring the 2 CTG Coordinators?
    Answer: It is ideal to have staff hired by the NC Action Institute in September 2012.

23. Since food costs are not allowed, are per diem reimbursements for meals at required meetings/trainings allowed?
    Answer: Per diem may be included in your travel budget, but the rate must be no more than the current state rates and must be justified in the budget narrative.

24. Will a letter of support from a district Board of Health suffice – or does the letter have to come from the Board of Commissioners? District Boards have total authority…
    Answer: Letters of support must come from the governing body that determines how local funds are spent.

25. What areas/programs/services are being funded at the state level to support communities in their efforts? (ex: media campaigns, etc)
    Answer: Support will be provided in each of the content areas as well as health equity/health disparities, communications, evaluation and training. Content and policy expertise will be available from the branches.

26. Can CTG grant funds be used for local Health Department Health Promotion positions that are not currently or will not be funded by State Health Promotion funds?
    Answer: It is essential that the staff assigned to the CTG project is qualified to implement the activities, regardless of previous positions. Staff supported by CTG funding must work on efforts that address the region's CTG goals.

27. If the performance measures are not met in accordance or to the satisfaction of the CDC, does the region have to re-pay the grant funds that were expended while trying to accomplish the goals?
    Answer: CTG funds will not need to be repaid if measures are not met; however continuation of funding is dependent on project performance.

28. Can our Region expect direct support from DPH in achieving the desired goals? How much guidance will be given?
    Answer: The designated DPH staff support will be in program assessment, planning, implementation, evaluation and communication. Content and policy expertise will be available from the branches.

29. We are asked to pick just four strategies for our first year's focus. Must these be regional strategies or can there be variance in focus by county depending upon local circumstances?
    Answer: The local CTG Leadership Team will determine how the strategies will be implemented across the region with technical assistance provided by DPH staff. CDC recommends choosing strategies that can be implemented with the greatest impact on population health and health disparities.

30. Your cover sheet says "electronic copies of the application are available by request" but right below it says "electronic copies of the application will not be accepted". What is the exact format you are expecting-Is it the 9 pages of narrative plus the items discussed on pages 22-30?
    Answer: Applications must be submitted in hard copy. All items listed on page 21 should be included in the application.

31. Page 6 says funds can be used for salaries/contracts for "new" positions. If we have health educators already employed in situations where their funding is disappearing, may we place these individuals on the grant instead of hiring "new" staff?
    Answer: It is essential that the staff assigned to the CTG project is qualified to implement the activities, regardless of previous positions. Staff supported by CTG funds must be actively engaged in CTG efforts. DPH

can provide information on the competencies needed to build support policy and environmental change and eliminate health disparities.

32. Are contracts with the Alliance acceptable in order to meet the staffing needs of the grant if we so choose?
Answer: Please reference the response to question # 3.

33. Can our “collaborative lead for communications” (p.7) be one of our two full time regional staff? We believe they will be in a better position to speak for the region rather than relying on a locally placed Health Educator no matter how qualified that person may be.
Answer: There should be a designated communications lead for the project outside of the Community Coordinators. An appropriate portion of this position can be supported by CTG funds.

34. Are the four strategies we select the only focal points where you expect us to focus 100% of our effort or are they the minimum number of strategies that you will accept?
Answer: These are the minimum number of strategies. As strategies are completed, applicants must move on to other strategic directions. For example, as some strategies are accomplished (such as smoke-free government buildings), the grantee can move on to another area in Tobacco Free Living.

35. We are asked to provide letters of support from various sources but many Boards of Health for example often do not meet monthly. Do we need to ask for a “called” meeting for the letter or can we state in the application that the letter is “on request” from a county or two if we have at least the lead county letter and several others in hand when the application goes in?
Answer: Letters of support must be included in the application. It is up to the lead agency to determine the need for a “called” meeting to meet this requirement.

36. Our most important question, as we look around our area for an Evaluator, it occurs to us that the whole state and each of the Regions may well be better served if DHP hires one single entity to do evaluation across all the projects as well as for the state initiatives themselves. We would expect much improved consistency in the process and we believe that there may well be economies of scale that will save us all money that can then be put to programmatic uses. Is this something under active consideration by DPH and could it be an opt in/out by each of the regions?
Answer: This is an option under consideration. The first step will be to decide what specific evaluation questions are most important to answer and then to outline the appropriate method for doing so and determine the appropriate lead agency/organization.

37. Since time is of the essence to DPH and we all want to show results, would DPH consider submitting HEED I and HEED II positions for blanket approval by OSP right now so that when the money comes we don’t all have to fight OSP individually?
Answer: Yes, this option is under consideration. We are working with staff in Human Resources to address this.

38. Please explain the various sources of funding that are likely to be available to local health departments for health promotion efforts. Specifically, address what, if any, additional funding may be available to local health departments for health promotion efforts. I understand that the "traditional" health promotion funds may be distributed differently than in years past, i.e. perhaps as a competitive grant proposal.
Answer: The new Healthy Communities grants that will be released in early 2012 will address physical activity, healthy eating and tobacco use. The current ESMM grant program addresses healthy eating and physical activity. We encourage regions to work together to coordinate funding opportunities based on need in the region.

39. Please explain in more detail what is meant by "supplanting funds supporting current positions". If a local health department or subcontractor chooses to devote a portion of a current position to this work and therefore proposed to change the funding for this position, .50 paid for by one source and the remaining .50 FTE paid for by CTG, is this appropriate?
Answer: Any position supported by CTG funding must dedicate the appropriate amount of time CTG efforts.

40. Based on what funds can be spent on and not spent on, is it correct that we can offer training and pay for all related expenses, but not be able to pay for refreshments at breaks or lunch for the training?
Answer: Training is an appropriate use of funds, however food items are not allowable (refreshments and lunch).

    b) Also related to the question of "not able to fund food items" - most of the model corner store initiatives offer in-store promotions to encourage patrons to try the healthier options. Would the grant be allowed to purchase produce or other healthy food options to offer an in-store taste-tasting event to encourage patrons to purchase items?

Answer: Food items are not an allowable cost for CTG.

c) Also along this line, many times farmers markets offer coupons to encourage people to try new items. Would the grant be able to subsidize these coupons? That is, the farmer turns in the coupon to the market manager and the manager submits a reimbursement to the grant for the amount of the coupons. See Announcement - Strategy 7, bullet number 7 and strategy 8, bullet number 6 - all as part of a promotional campaign.
Answer: Food items are not an allowable cost for CTG.

41. Is there a limit to the number of positions that can be hired? I see that the grant requires certain staffing levels, but is this just considered the minimum staffing level? If we chose to use a portion of the funding for the financial support role, can we use grant funds to hire this position? The language says "designate a fiscal staff", but what if the agency saw the need to hire a part-time FTE for this role?
Answer: There is no limit on the number of positions hired through CTG. However, all positions must be justified.

42. Page 24 # 3 of the announcement is asking for MOUs with other health departments, followed by letter of support from BOH and BOCC or Manager. Are the letter of supports needed from all of the BOHs and Commissioners/ Managers for each of the counties participating or just the lead county?
Answer: The intent of the letters of support is to demonstrate support from the lead county's appropriate authority for distributing funds to other health departments in the region.

43. Explain the budget cycle for this grant. I see that we will submit budgets from March to May and assume that is to coincide with the State fiscal calendar. Why is the next budget cycle identified as June 2012 - September 2012?
Answer: The budget cycle for this grant is September 30, 2011-September 29, 2012. This is the federal fiscal year, which crosses 2 state fiscal years. Therefore, 2 budgets should be submitted.

44. Rural & Urban county designations seem a bit off….how were these determined? Ex: Person as 'urban', even Orange to some extent.
Answer: CDC has stated that, for the purposes of CTG, all counties that are not part of a Metropolitan Statistical Area are considered "rural." Metropolitan Statistical Areas (MSAs) are geographic entities defined by the Office of Management and Budget (OMB). The process of identifying an MSA begins with the identification of a core urban area of 50,000 or more population (which may be contained in a single county or spread across multiple counties). Then, the MSA is defined as the county or counties containing the identified core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core.
For more information: http://www.census.gov/population/metro/

45. Does the Lead also have to be the fiscal agent? Not clear.
Answer: The lead agency is defined as the fiscal agent.

46. Do all the counties in a region have to participate? Consequences?
Answer: All counties in a region do not have to participate in CTG efforts. Work should be prioritized in areas where the greatest health disparities exist and there is readiness to implement change. While each county will not receive direct funding, all should benefit from policy, systems and environmental changes resulting from the efforts.

47. If the money isn't going to be divvied up among the partners, what's the incentive to participant? In reality, without $ how is work to get done? Currently, in many counties, this work is being done by people on grants or contract addenda that won't exist after June.
Answer: The goal of CTG is to establish policy, environmental and systems changes and to reduce chronic disease disparities. Work in areas where the greatest health disparities exist should be prioritized. While each county will not receive funding, all should benefit from training, technical assistance and policy, systems and environmental changes resulting from the efforts.

48. It seems the required 2 Coordinator positions supplant all the various PAN & TPCB consultants and TAs---what is the purpose for spending a majority of the limited funds on hiring duplicative staff? Basically, managers need bodies in the field to do work not supervise work. As state funds have disappeared so has the local staff, counties aren't picking up the cost.
Answer: CTG funding is not intended to replace any other funding. Positions supported by CTG funding must work on efforts that support the region's CTG goals.

49. If we are not a rural county but we want to participate in the collaborative, how will we be expected to "prioritize work in rural counties"? What does this mean for non-rural counties and/or non-lead counties?

Answer: The local CTG Leadership Team will determine how the strategies will be implemented across the region with assistance provided by DPH staff.

50. On Page 8 (and in a few other places), the RFA refers to "program staff" within the collaborative. For example, "program staff will be required to participate in DPH training events." How is "program staff" defined? Is it the CTG-funded folks from the lead county, or does each county need to have someone designated as "program staff" for these trainings?
    Answer: The staff supported by CTG funding will be required to attend trainings.

51. Regarding Strategy Direction II, Active Living, #6, "Increase the number of communities that implement comprehensive plans for land use and transportation": Will the DPH consultants managing this grant be able to provide the collaboration and buy-in needed from NCDOT to support this on a local level? It is our understanding that in many cases, getting cooperation from NCDOT with regard to "bikeability" and "walkability" is key to making these changes possible; it would be wonderful to have some doors opened for this at the state level.
    Answer: Partnerships at the state will be working on the issues that local communities will be engaged in across all of the Strategic Directions.

52. Will the funds represented by the CTG replace funding currently provided to LHDs through the state's Health Promotion and Tobacco initiatives?
    Answer: CTG funding is not intended to replace any other funding. Positions supported by CTG funding must work on efforts that support the region's CTG goals.

53. Does the rural coordinator have to be housed in a rural county or can it be housed in an urban county and simply serve rural counties?
    Answer: While the "rural coordinator" can be housed in an urban county, it must serve the rural areas of the region.

54. Our region has many more urban counties versus rural counties. Can the rural coordinator serve urban counties in addition to rural counties to balance the work between the two coordinators?
    Answer: The rural coordinator can serve urban counties in addition to the rural counties.

55. The RFA requests that we submit two budgets (March 2012-May 2012 and June 2012-September 2012). Because it is not a standard one year budget, can you clarify whether there are specific items/explanations you require for each of the two periods?
    Answer: The budget needs to align with the state fiscal years.

56. The RFA states there are two trainings requiring travel scheduled for year one (Kickoff in April and NC Action Institute in September). For budgetary purposes, should we estimate travel costs for the two primary coordinators only or should all counties in the collaborative send a representative? You suggest sending Health Directors as well. Should we estimate costs to send the Health Director from the lead county only or HD from all counties?
    Answer: The 2 CTG Coordinators and the Health Directors from their respective counties should attend the CTG Kickoff meeting. 8-10 members of the local CTG Leadership Team should attend the Action Institute in December.

57. Can you explain in more detail what will be expected as part of the grant's evaluation? What is your expectation in terms of dedicating sufficient resources towards evaluation?
    Answer: We do not yet have a detailed evaluation plan. In addition to performance monitoring, we anticipate that outcome evaluations focused on specific strategies, target populations, and or sites/places will be part of CTG. The intention of these evaluations will be to add to the evidence base, which is a key component of CTG nationwide. Ideally, these outcome evaluations will provide funded regions with the opportunity to look into issues of particular interest and relevance to them (e.g., addressing a particular regional health disparity or measuring progress on a strategy of particular interest). We also expect that North Carolina will be participating in various pieces of the multi-faceted CTG evaluation that CDC is coordinating, potentially including targeted surveillance, a cost study, and/or special national evaluation studies. In terms of resources, CDC has budgeted 10% of the national CTG budget to evaluation, and we ask grantees to be willing to do the same if needed.

58. The RFA specifies that all counties must address a particular strategy in Strategic Direction I and III. Are we expected to address a second strategy in each of those strategic directions as well?
    Answer: Applicants must describe how they will address one strategy in each of the four Strategic Directions. Applicants are not expected to address every strategy in year 1. As strategies are completed, grantees must move on to other strategies within the Strategic Direction.

59. Is there a maximum number of letters of support we can include with the application?
    Answer: There is not a maximum number of letters of support included in the application. It is important to demonstrate the support of the lead county's governing agency that determines how funds are allocated locally.

60. Region V has only one designated rural county out of nine. Is it expected that 36% of the total annual amount of this grant ($144K) will go only to projects in that one county, or is it anticipated that rural areas of other designated "metro" counties could also be served? This is especially a concern because every county in our region has a food desert except for the designated rural county.
    Answer: The state is expected to dedicate 36% of the total award to work in rural counties. This percentage is not expected at a local level.

61. If a region wishes to remove counties from their region and add counties from another region to their county groupings, should that be OK'd with the state prior to the letter of intent? Is there a formal process for creating groupings other than the prescribed region?
    Answer: Regions can realign as they deem appropriate. Participating counties must be outlined in the Letter of Intent.

62. Can a region choose to have one county serve as the fiscal agent for the grant, and another county serve as the lead for the activities around the Strategic Directions outlined in the grant, particularly if neither County is a rural county?
    Answer: The lead agency is the fiscal agent. One of the two CTG Community Coordinators must address rural areas. Other positions may be dedicated to particular Strategic Directions.

63. Would you please clarify the role of Wake and Mecklenburg Counties regarding this grant and their role within their districts?
    Answer: Due to CDC's requirements Wake and Mecklenburg can be involved in regional strategic planning, trainings, etc. However, they cannot receive resources to hire staff that serves those counties.

64. Does each county in the region have to fulfill all the Strategic Direction activities the region decides on or can one county fulfill one strategic direction and another county fulfill another strategic direction?
    Answer: The local CTG Leadership Team will determine how the strategies will be implemented across the region with assistance provided by DPH staff.

65. Do formal contracts with CBOs have to be used in each county of a region or can some counties opt not to subcontract with a CBO, particularly if target population participation can be solicited through other types of partnerships or less formal participation.
    Answer: The local fiscal agency needs to determine the appropriateness of contracts and subcontracts.

66. Does the "lead county" have to take the lead on all the strategic directions, even if the project does not fall in their county, or can counties other than the lead county choose to take the lead on a specific Strategic Direction?
    Answer: The local CTG Leadership Team will determine how the strategies will be implemented across the region with assistance provided by DPH staff.

67. Does major responsibility for Strategic Direction III lie with the regional AHECs and do they take the lead on this activity? Please clarify the role of the AHEC's in this project.
    Answer: DPH will work with the appropriate state partners to lead Strategies 9 and 10.

68. Does money for Strategic Direction III (Evidence-based Clinical/Preventive Services) come out of the region's $400K, or does the state supply this to the AHEC's separately?
    Answer: Funding for the work to increase the number of healthcare providers who utilize quality improvement systems for the clinical management of high blood pressure and high cholesterol, weight management and tobacco cessation will be not be a part of the region's budget.

69. Are state health promotion monies going away permanently and do we anticipate this same work being supplanted by CTG grant funds?
    Answer: SWHP ends May 30, 2012. CTG work is significantly different from SWHP. Your staff may or may not be appropriate candidates to work on these efforts. CTG funding is not intended to supplant SWHP funding.

70. Evaluation can be up to 10% of the grant regionally. When the grant asks for evaluation services, how will this differ from the reports that the state will be monitoring? What exactly do you want to be evaluated at the regional level?

Answer: We do not yet have a detailed evaluation plan. In addition to performance monitoring, we anticipate that outcome evaluations focused on specific strategies, target populations, and or sites/places will be part of CTG. The intention of these evaluations will be to add to the evidence base, which is a key component of CTG nationwide. Ideally, these outcome evaluations will provide funded regions with the opportunity to look into issues of particular interest and relevance to them (e.g., addressing a particular regional health disparity or measuring progress on a strategy of particular interest). We also expect that North Carolina will be participating in various pieces of the multi-faceted CTG evaluation that CDC is coordinating, potentially including targeted surveillance, a cost study, and/or special national evaluation studies. In terms of resources, CDC has budgeted 10% of the national CTG budget to evaluation, and we ask grantees to be willing to do the same if needed.

71. Who do you anticipate contracting for evaluation? Must it be a university? Can it be a private contractor? Could the Health Department conduct the evaluation themselves if they had the capacity?
Answer: All three of these are possibilities for the funded regions, and each option has its benefits. A region's unique context (e.g., specific evaluation interests, internal evaluation capacity, partnerships and past experience with universities or private contractors) will be a major factor in deciding which option is best.

72. Do you anticipate needing IRB approval for any of the evaluation at the local level?
Answer: Some of the evaluation work that we anticipate will occur through CTG may require IRB approval. As evaluation plans come together, this will be an important issue to look into. One point worth clarifying here is that CTG funding may not be used for research.

73. Other than the two paid staff people mentioned in the grant, would there be a way to reimburse for the time expended by other staff people in a non-lead county on particular initiatives?
Answer: There is no limit on the number of positions hired through CTG. However, all positions must be justified.

74. If a staff person in one county takes the lead on a particular project in the region, can that staff person be partially compensated by grant funds to offset the fact that they will lose capacity to operate within their current grant in their home county? The RFP clearly says that funds cannot be used to support current positions, but it would be difficult for staff people to add other counties to their duties without compensation or funding to hire someone to take over their current grant responsibilities.
Answer: There is no limit on the number of positions hired through CTG. However, all positions must be justified.

75. Per the RFA, $144K (36% of $400K) has to go to rural counties in each region. Do the salaries of the two required position come out of this pot or does it come from the remaining $256K?
Answer: The state is expected to dedicate 36% of the total award to work in rural counties. This percentage is not expected at a local level.

76. Will the CTG money be distributed in more than one disbursement during the year?
Answer: Funds will be budgeted in the WIRM by state fiscal year.

77. What is the yearly service period for the grant?
Answer: The service period will be reflected in the WIRM for each fiscal year.

78. Region 5 has asked Wake Co to be involved in their application for the CTG. Is Wake allowed to participate? And if so in what ways?
Answer: Due to CDC's requirements Wake and Mecklenburg can be involved in regional strategic planning, trainings, etc. However, they cannot receive resources to hire staff that serve those counties.

79. We will not be the lead county and have an employee who will only receive partial funding from the county; can we use the funds to pay the difference in her salary if her responsibilities include those deliverables outlined in the RFA?
Answer: There is no limit on the number of positions hired through CTG. However, all positions must be justified.

80. Cleveland County is technically not in Region 4 but has historically participated in our region's meetings/activities and would like to do so for the CTG project. Is there anything we need to do to "acknowledge or authorize" their participation in Region 4's CTG project?
Answer: Regions can realign as they deem appropriate. Participating counties must be outline in the Letter of Intent.